

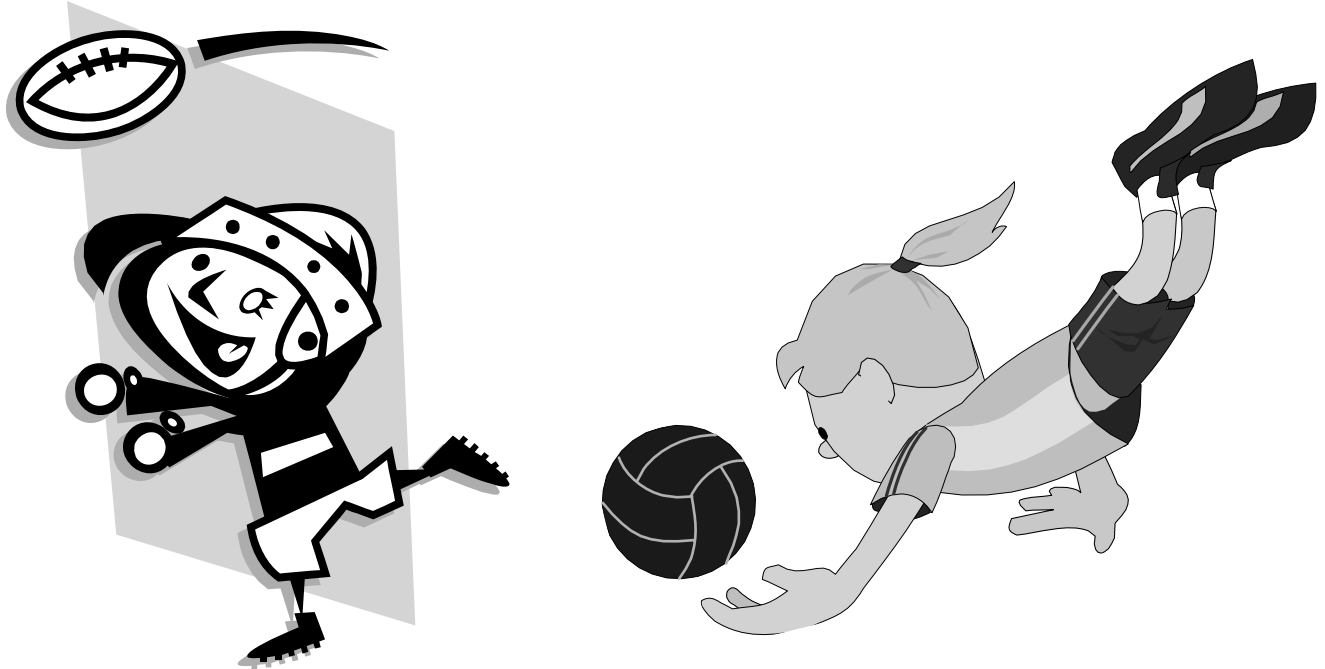
# BOYS FOOTBALL/GIRLS VOLLEYBALL

For WSD Students Only

## Washington School for the Deaf



August 20-25, 2007



## Summer Sports Camp 2007 Registration Packet

# Washington School for the Deaf

## Summer Sports Camp 2007

### Registration Packet

**Grades 8-12th**

**August 19-25th, 2007**

**August 19 - AFTER 5pm**

**Camp & Lodging**

**\$160 if received by July 14, 2007**

**\$180 if received after July 14, 2007**



**Registration Deadline August 4, 2007**

**Boys Football Camp:** WSD students grades 8-12 will have the chance to begin their practice early to meet WIAA practice days before the first game.

**Girls Volleyball Camp:** WSD students grades 8-12 will have the chance to begin their practice early to meet WIAA practice days before the first game.



**All information must be filled out completely and requested documents must be attached before your child will be accepted.**

***Upon Arrival:***

***Guardian/Parent must sign in student with WSD Staff Member in cottages.***

**Required pages:**

**Pages 4-8 and either Physical Examination Update or Physical Examination located in the back of this packet.**

***These pages need to be filled out completely.***

# Parent Information

## Pre-Registration Required:

All applications must be filled out completely and mailed with the total fee to:

Washington School for the Deaf  
Summer Sports Camp 2006  
611 Grand Blvd  
Vancouver, WA 98661

## NO WALK-INS ALLOWED

## Payment Information:

WSD accepts cash, checks and money orders.

If you have any questions regarding payment options, contact Kay Pedisich in the Business Office at 360.696.6525 ext. 0417 or [kay.pedisich@wsd.wa.gov](mailto:kay.pedisich@wsd.wa.gov).

Full payment or payment arrangements must be made prior to the **registration deadline: August 4th 2007**.

Scholarships are available for low income families. WSD uses the federal USDA income guidelines to determine eligibility.

## Refund Policy:

- ⇒ 95% of the amount paid will be refunded IF you cancel at least two weeks prior to the start date of the camp.
- ⇒ 50% of the amount paid will be refunded IF you cancel one week prior to the start date of the camp.
- ⇒ No refund will be given after one week prior to the start date of the camp

## Visitation:

Attending camp provides an extraordinary opportunity for participants to gain language skills, self-reliance, self-confidence, and independence important to a child or teen's development; therefore the camp program should not be interrupted with visits by parents or relatives. We highly recommend parents visit camp on opening and closing days *only*.

**Letters and Packages:** Please address letters and packages to the camp participant in the following format:

Washington School for the Deaf  
Summer Sports Camp 2007  
Child's Name  
611 Grand Blvd  
Vancouver, WA 98661















**Telephone Calls:** 360.696.6525 ext. 4361

For more information contact Ron Spratlen at 696-6525 ext. 4354  
[ron.spratlen@wsd.wa.gov](mailto:ron.spratlen@wsd.wa.gov)










**Registration deadline is August 4th, 2007**

# What to Bring

## Recommended:

-  **\$25.00 for snacks and recreation**
-  **Enough clothing for one week (including undergarments)**
-  **Tennis shoes**
-  **Bathing suit**
-  **Pajamas**
-  **Toothbrush, toothpaste (dental care needs)**
-  **Shampoo**
-  **Deodorant**
-  **Sunblock lotion**
-  **Comb or brush**
-  **Hair bands (for long hair)**
-  **Soap and soap dish**
-  **Water bottle**
-  **Small bag of laundry soap**

## Optional:

-  **Pillow**
-  **Phone card or prepaid phone card**
-  **Camera and film**
-  **Sunglasses**
-  **Extra pair of glasses/contact lenses and supplies to maintain**
-  **Swim goggles, earplugs, nose plugs**
-  **Playing cards**
-  **Books**
-  **Hat**

**Please mark your child's name clearly on all items!**

**SHEETS, PILLOW CASES, BLANKETS, TOWELS AND WASHCLOTHES  
WILL BE FURNISHED TO ALL PARTICIPANTS.**

# PARENT REGISTRATION FORM

## Washington School for the Deaf

### Summer Sports Camp 2007

***DEADLINE FOR REGISTRATION IS AUGUST 4, 2007.***

There are five required pages included in this registration packet.  
Everything must be filled out completely and signed  
or your package will be returned to you for completion.  
(PLEASE TYPE OR PRINT LEGIBLY)

**Sign Up Early!**

**Please check session(s) desired:**

	Football Camp	August 19-25 Registration Deadline: 8/4/07	\$ 160 (includes camp and lodging)
	Volleyball Camp	August 19-25 Registration Deadline: 8/4/07	\$ 160 (includes camp and lodging)

**Total Enclosed** \_\_\_\_\_

#### Participant Information:

Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother's Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

#### FOR SCHOLARSHIP APPROVAL:

Please provide your total monthly income or TANF Case number: \_\_\_\_\_

#### For Office Use Only

Date Received: \_\_\_\_\_

Deposit Amount: \_\_\_\_\_

[ ] Check [ ] Money Order [ ] Purchase Order

Receipt #: \_\_\_\_\_

Letter Sent: \_\_\_\_\_

**REQUIRED PAGE**

# Washington School for the Deaf Summer Sports Camp 2007

Washington School for the Deaf Expectations and Agreements:

**\* TO BE SIGNED BY THE PARTICIPANT AND PARENT/GUARDAIN \***

## Personal Loss:




I understand that Washington School for the Deaf does not cover theft, loss, or damage to my child's personal equipment or property. I understand that Washington School for the Deaf recommends that I check with my personal insurance coverage to confirm my insurance will cover any loss. Parent/Guardian Initials \_\_\_\_\_ Student Initials \_\_\_\_\_

## Damage to Washington School for the Deaf Property:

I understand that I will be responsible for all costs incurred if my child damages any Washington School for the Deaf property. I understand that if the damage is serious enough, the local law enforcement will be involved.

Parent/Guardian Initials \_\_\_\_\_ Student Initials \_\_\_\_\_

## Expectations:

-  The primary responsibility of Washington School for the Deaf staff is to keep participants safe. We hope you will respect their responsibility and we expect you to abide by the rules set in order to keep you and the entire group safe physically and emotionally.
-  Camp is a group experience; your attitude influences the group. Positivity is expected; you don't have to love everything we do, only appreciate that you have done it. Also, we aim to maintain a non-exclusive group, your participation in that effort is required.
-  We expect human kindness and appreciation of differences.

I agree that I will not participate in any illegal activity during any part of the camp, including but not limited to, use or possession of alcohol, tobacco, weapons, or any controlled substance. I will treat each team member with equal respect and fairness. I agree that any disregard for these guidelines, or other behavior detrimental to the group, may result in my dismissal from the summer camp. In the event that I am dismissed I understand that my parent/guardian is responsible to pick me up immediately. There will be no monetary refunds for participants who are dismissed for disciplinary reasons. There will be no monetary refunds or reductions in fees for participants who arrive late or leave early for personal/family reasons. I have read the above agreements with my parents/guardians and agree to abide by them.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Washington School for the Deaf Summer Sports Camp 2007

Washington School for the Deaf Expectations and Agreements (continued):

**\* TO BE SIGNED BY THE PARENT/GUARDAIN \***

**Photo Release:**

I ☐ do/☐ do not hereby give Washington School for the Deaf and its assigns, licensees, or legal representative the right to use my child's photograph in all forms of media and in all manners, including composite or other representations, for advertising, trade or other lawful purposes. Washington School for the Deaf will make every attempt possible to send me a copy of the publication.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Field Trip:**

I, \_\_\_\_\_ (parent/guardian), give permission for my child to ride in WSD state vehicles.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Field Trip Locations	
These are the locations we may be traveling this year for the 2007 Summer Sports Camp. Please make sure to keep a copy.	
Sports Activities	Meals
Clackamas Aquatic Park	Old Country Buffet
Clark Community College	Izzy's Pizza
Kiggins Bowl	Old Spaghetti Factory
Kiggins (Movie Theater)	Pizza Hut
Marshall Center	Smokey's Pizza
Portland Coliseum	
Portland Rose Garden	
Portland State University	
Vancouver Mall	
Washington State School for the Blind	
Y.M.C.A.	

**REQUIRED PAGE**

# Health Information

Camper Information	Camper's Name		Last	First	Middle Initial
	Street Address			Birth Date	Age
	City			State	Zip Code
			Gender (circle one) F M		

Parent/Guardian	Name of Parent or Guardian		Telephone
			Email
	Street Address		Mother's Cell Phone/Pager
	City	State	Zip Code
		Father's Cell Phone/Pager	

Insurance Information	Name and Address of Insurance Company	
	Policy and Group Numbers/Medicare/Union and Local	My Insurance is Through: <input type="checkbox"/> Employment <input type="checkbox"/> Private
	Name and Address of Additional Insurance Company	
	Policy and Group Numbers/Medicare/Union and Local	

Friend/Relative	Name of Local Friend or Relative Other than Listed Above for Emergency Contact	Relationship
	Telephone Number	Cell Phone Number

## Required for participation:

***Sports physicals are required every 2 years to participate in athletics.***  
Please include **Physical Examination Update** if physical was received last year. If your child did not receive a physical last year please include new **Physical Examination** located in the back of this packet.



# Health Information

Student Name: \_\_\_\_\_

Family Doctor (Name & Address):

\_\_\_\_\_  
\_\_\_\_\_

Family Dentist (Name & Address):

\_\_\_\_\_  
\_\_\_\_\_

Family Pharmacist (Name & Address)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies:

\_\_\_\_\_  
\_\_\_\_\_

Last Date of Tetanus Shot:

\_\_\_\_\_

## Medical Care:

This is to authorize medical personnel at the Summer Sports Camp 2007 at the Washington School for the Deaf and/or other doctors so designated to provide medical treatment and administer anesthetic by qualified personnel to my child if it becomes necessary.

Summer Sports Camp 2007 at the Washington School for the Deaf staff has the right to give first aid treatment to any camper. Staff shall also have the right to seek and retain services of medical emergency or rescue personnel, and if necessary to treat and/or hospitalize a camper.

Campers are responsible for providing their own medical insurance coverage. Responsibility for any medical expense, evacuation and/or emergency transportation incurred by the participant is to be borne by the camper and parent/guardian.

Summer Sports Camp 2007 at the Washington School for the Deaf does not provide medical insurance coverage for campers, and will not be held responsible for any medical expenses under any circumstances.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical Release Consent:

The medical staff has my permission to obtain or release medical information from or to any doctor or medical vendor deemed necessary in the treatment of my child while a camper is at Summer Sports Camp 2007.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

REQUIRED PAGE

## PHYSICAL EXAMINATION UPDATE

(Statement For Continued Participation)

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

School \_\_\_\_\_ Grade 8 9 10 11 12  
(circle one)

**WIAA Regulation - PHYSICAL EXAMINATION** - Prior to the first practice for participation in interscholastic athletics in a middle level school and prior to participation in a high school, a student shall undergo a thorough medical examination and be approved for interscholastic athletic competition by a medical authority licensed to perform a physical examination. This physical examination must include, but not necessarily be limited to:

- A. Documentation of a detailed review of the student's medical history with special attention to presence or absence of cardiovascular/pulmonary risks and/or previous significant injury and rehabilitation therefrom.
- B. Documentation of satisfactory examination of the cardiopulmonary system.
- C. Documentation of satisfactory sport specific orthopedic screening examination.
- D. A written statement by the examiner as to the fitness of the student to undertake the proposed athletic participation, together with suggestion for activity modification if necessary.

\*\*\*\*\*

### EXAMINER'S CERTIFICATION:

Date of last complete physical examination \_\_\_\_\_

I hereby certify that the above-named individual's physical condition is adequate to participate in supervised interscholastic activities **NOT CROSSED OUT BELOW**:

BASEBALL BASKETBALL CROSS COUNTRY DANCE/DRILL FOOTBALL GOLF  
GYMNASTICS SOCCER SOFTBALL SPIRIT SWIMMING TENNIS TRACK  
VOLLEYBALL WRESTLING Other \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Examiner's Signature

\_\_\_\_\_  
Examiner's Name (Print)

### MEDICAL AUTHORITIES LICENSED TO GIVE PHYSICAL EXAMINATIONS

- |                                       |  |
|---------------------------------------|--|
| 1. Medical Doctor (MD)                | 4. Medics - Physician Assistant (P.A.) |
| 2. Doctor of Osteopathy (D.O.)        | 5. Naturopaths (N.D.)                  |
| 3. Certified Nurse Practitioner (CRN) |  |

## PHYSICAL EXAMINATION

### Optional

Age: \_\_\_\_\_ Pulse: \_\_\_\_\_

Height: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Weight: \_\_\_\_\_ Visual Acuity: Left 20/ \_\_\_\_\_  
Right 20/ \_\_\_\_\_

Urinalysis:
Body Fat %
HCT:
EST VO2 Max:
Audiometry:

#### Normal

- |                          |     |                              |
|--------------------------|-----|------------------------------|
| <input type="checkbox"/> | 1.  | Head                         |
| <input type="checkbox"/> | 2.  | Eyes (pupils), ENT           |
| <input type="checkbox"/> | 3.  | Teeth                        |
| <input type="checkbox"/> | 4.  | Chest                        |
| <input type="checkbox"/> | 5.  | Lungs                        |
| <input type="checkbox"/> | 6.  | Heart                        |
| <input type="checkbox"/> | 7.  | Abdomen                      |
| <input type="checkbox"/> | 8.  | Genitalia                    |
| <input type="checkbox"/> | 9.  | Neurologic                   |
| <input type="checkbox"/> | 10. | Skin                         |
| <input type="checkbox"/> | 11. | Physical Maturity            |
| <input type="checkbox"/> | 12. | Spine, Back                  |
| <input type="checkbox"/> | 13. | Shoulders, Upper extremities |
| <input type="checkbox"/> | 14. | Lower extremities            |

#### Abnormal

- |                          |  |  |
|--------------------------|--|--|
| <input type="checkbox"/> |  |  |
| <input type="checkbox"/> |  |  |
| <input type="checkbox"/> |  |  |
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| <input type="checkbox"/> |  |  |
| <input type="checkbox"/> |  |  |
| <input type="checkbox"/> |  |  |

Assessment: ☐ Full participation  
☐ Limited participation (describe limitations, restrictions):

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Participation contraindicated (list reasons):

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Recommendations (equipment, taping, rehabilitation, etc.):

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DATE: \_\_\_\_\_ EXAMINER'S SIGNATURE: \_\_\_\_\_  
EXAMINER'S PHONE: (    ) \_\_\_\_\_ PRINT EXAMINER'S NAME: \_\_\_\_\_

## PREPARTICIPATION HISTORY AND PHYSICAL EXAMINATION

This form is not required as long as the conditions of 18.13.0 are met.

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Exam Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Sport: \_\_\_\_\_

### HISTORY

- |       | Yes                      | No  |
|-------|--------------------------|---|
| 1 a.  | <input type="checkbox"/> | <input type="checkbox"/> Have you had any illness/injury recently, or do you have an illness/injury now?                    |
| b.    | <input type="checkbox"/> | <input type="checkbox"/> Have you had a medical problem, illness or injury since your last exam?                            |
| c.    | <input type="checkbox"/> | <input type="checkbox"/> Do you have any chronic or recurrent illness?  |
| d.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had any illness lasting more than a week?  |
| e.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever been hospitalized overnight?   |
| f.    | <input type="checkbox"/> | <input type="checkbox"/> Have you had any surgery other than tonsillectomy?   |
| g.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had any injuries requiring treatment by a physician?                                 |
| h.    | <input type="checkbox"/> | <input type="checkbox"/> Do you have any organ missing other than tonsils ( appendix, eye, kidney, testicle, etc.)?         |
| 2.    | <input type="checkbox"/> | <input type="checkbox"/> Are you presently taking ANY medications ( including birth control pill, vitamin, aspirin, etc.)?  |
| 3.    | <input type="checkbox"/> | <input type="checkbox"/> Do you have ANY allergies (medicines, bees, foods, or other factors)?                              |
| 4 a.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had chest pain, dizziness, fainting, passing out during or after exercise?           |
| b.    | <input type="checkbox"/> | <input type="checkbox"/> Do you tire more easily or quickly than your friends during exercise?                              |
| c.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had any problem with your blood pressure or your heart?                              |
| d.    | <input type="checkbox"/> | <input type="checkbox"/> Have any close relatives had heart problems, heart attack or sudden death before they were age 50? |
| 5.    | <input type="checkbox"/> | <input type="checkbox"/> Do you have any skin problems (acne, itching, rashes, etc.)?                                       |
| 6 a.  | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had fainting, convulsions, seizures or severe dizziness?                             |
| b.    | <input type="checkbox"/> | <input type="checkbox"/> Do you have frequent severe headaches?   |
| c.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a "stinger" or "burner" or "pinched nerve"?                                      |
| d.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever been "knocked out" or "passed out"?  |
| e.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a neck or head injury?   |
| 7.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had heat exhaustion, heat stroke, heat cramps or similar heat-related problems?      |
| 8.    | <input type="checkbox"/> | <input type="checkbox"/> Have you had asthma, or trouble breathing, or cough during or after exercise?                      |
| 9 a.  | <input type="checkbox"/> | <input type="checkbox"/> Do you wear eyeglasses, contact lenses or protective eye wear?                                     |
| b.    | <input type="checkbox"/> | <input type="checkbox"/> Have you had any problem with your eyes or vision?   |
| 10.   | <input type="checkbox"/> | <input type="checkbox"/> Do you wear any dental appliance such as braces, bridge, plate, retainer?                          |
| 11 a. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a knee injury?   |
| b.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had an ankle injury?   |
| c.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever injured any other joint (shoulder, wrist, fingers, etc.)?                            |
| d.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a broken bone (fracture)?  |
| e.    | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a cast, splint, or had to use crutches?  |
| f.    | <input type="checkbox"/> | <input type="checkbox"/> Must you use special equipment for competition (pads, braces, neck roll, etc.)?                    |
| 12.   | <input type="checkbox"/> | <input type="checkbox"/> Has it been more than 5 years since your last tetanus booster shot?                                |
| 13.   | <input type="checkbox"/> | <input type="checkbox"/> Are you worried about your weight?   |
| 14.   | <input type="checkbox"/> | <input type="checkbox"/> FEMALES: Have you any menstrual problems?  |
| 15.   | <input type="checkbox"/> | <input type="checkbox"/> Have you any medical concerns about participating in your sport?                                   |

\*\*\*\*\* ATHLETE SHOULD NOT WRITE BELOW THIS LINE \*\*\*\*\*

EXAMINER'S COMMENTS ON ALL "YES" ANSWERS (refer to question number):

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